UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Tara Gustilo, M.D. Plaintiff, vs. Hennepin Healthcare System, Inc. Defendant.	Case No. 22-cv-0352 (SRN/HB) **DEFENDANT HENNEPIN HEALTHCARE SYSTEM, INC.'S FIRST SET OF INTERROGATORIES TO PLAINTIFF**

TO: PLAINTIFF AND HER ATTORNEYS OF RECORD, DANIEL J. CRAGG AND ANNE N. ST. AMANT, ECKLAND & BLANDO LLP, 800 LUMBER EXCHANGE BUILDING, 10 SOUTH FIFTH STREET, MINNEAPOLIS, MN 55402:

Please answer these interrogatories under oath within 30 days pursuant to Rule 33 of the Federal Rules of Civil Procedure:

1. Please identify by name and current or last known address and telephone number each and every person who has or claims to have any knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

2. Please describe in detail plaintiff's efforts to obtain other employment outside of Hennepin Healthcare System, Inc. since January 2021. When answering this interrogatory, please provide a list of positions for which plaintiff applied (employer, job title, duties of position, compensation); when and how plaintiff applied; how far plaintiff's application progressed; any reason the prospective employer gave for not hiring plaintiff; and identify all documents relating, regarding, or referring to plaintiff's job search efforts.

3. Has plaintiff secured a job with another employer? If so, please state the name and address of the employer, the date plaintiff is expected to begin work with this employer, whether the job is on a full-time basis, plaintiff's job title and duties, and specific information regarding wages and benefits.

4. Identify all sources of income, besides wages earned working for defendant, since January 2021.

5. Does plaintiff claim lost earnings as a damage in this action? If the answer is yes, please describe the amount of loss, the period over which the loss occurred, and how plaintiff calculated each component of her alleged lost earnings, including mitigation and off-sets.

6. Does plaintiff claim diminution or loss of earning capacity as a damage in this action? If the answer is yes, please describe the nature and extent of this loss, how plaintiff calculated each component of her alleged diminution or loss of earning capacity, including mitigation and off-sets, and the manner in which its present value is calculated.

7. Please state in detail, and not in summary fashion, all medical, physical, and emotional injuries and damages that plaintiff claims to have suffered as a result of the alleged acts and/or omissions of defendant.

8. If plaintiff claims medical, physical, and/or emotional damages in this action, please identify by name and address each and every physician, medical practitioner, or other healthcare practitioner whom she consulted or who provided advice, treatment, or care to her at any time and, with respect to each contact, consultation, treatment, or advice, describe the same with particularity and indicate the reasons for the same.

9. Itemize all special damages which plaintiff claims in this case and specify, where appropriate, the basis and reason for plaintiff's calculation as to each item of special damages.

10. As to each expert whom plaintiff expects to call as a witness at trial, please state:

    a. The expert's name, address, occupation, and title;

    b. The expert's field of expertise, including subspecialties, if any;

    c. The expert's educational background;

    d. The expert's work experience in the field of expertise;

    e. All professional societies and associations of which the expert is a member; and

    f. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

11. With respect to each person identified in the foregoing interrogatory, state:

    a. The subject matter on which the expert is expected to testify;

    b. The substance of the facts and opinions to which the expert is expected to testify; and

    c. The grounds for each opinion, including the specific factual data upon which the opinion will be based.

12. If plaintiff has ever been a party to a lawsuit state the title of the suit, the court file number, the date of filing, the specific nature of the claim, and the ultimate disposition of the claim.

13. Set forth in detail anything said or written by which plaintiff claims to be relevant to any of the issues in this lawsuit, identifying the time and place of each statement, who was present, and what was said by each person who was present.

14. Please state whether plaintiff claims that defendant violated any standard, rule, statute, ordinance, or regulation that is relevant to the allegations contained within plaintiff's Complaint.

15. With respect to any violation claimed in response to the previous interrogatory, please state:

    a. The standard, rule, statute, ordinance, or regulation that was violated;

    b. The person(s) who committed such violation;

    c. The precise nature of each such violation; and

    d. The causal relationship of each such violation to the injuries plaintiff claims to have suffered.

16. Does plaintiff claim that defendant made admissions against interest? If the answer is yes, please provide: (a) the date of the admission; (b) the nature of the admission (whether the alleged admission was oral or in writing); and (c) the name and address of any witnesses who heard or saw the alleged admission.

17. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 24 of the Complaint that defendant "was fostering" a "discriminatory and retaliatory environment."

18. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 87 of the Complaint that she "voiced her dissent against Defendant's discriminatory actions." For each instance where plaintiff claims she voiced her dissent, state the date, to whom she voiced dissent, what was said, and a list of all witnesses present.

19. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 92 of the Complaint that defendant "demoted Plaintiff for her advocacy for equality and non-discrimination, and willfully deprived Plaintiff of her constitutional right to freedom of speech."

20. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 93 of the Complaint that "Plaintiff's protected activity was a substantial and motivating factor in Defendant's actions" to remove her from the chair position.

21. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 105 of the Complaint that defendant "discriminated against Plaintiff when she refused to subscribe to the ideology expected of her as a person of color, and was instead punished for her 'internalized whiteness.'"

22. Set forth in detail all facts and documents upon which plaintiff relies for her claim in paragraph 110 of the Complaint that "Defendant, as the perpetrator of discrimination, intentionally engaged in reprisal against Plaintiff."

23. Set forth in detail all facts and documents upon which plaintiff relies for her claim that the decision to remove her from the chair position was based upon her race.

24. Describe in detail, and not in summary fashion, each and every instance of an unlawful employment practice plaintiff is alleging against defendant, including: the specific nature of the alleged unlawful employment practice; the date of the alleged incident; the name of defendant's employee responsible for the alleged incident; the names of any witnesses; whether plaintiff made a complaint to an employee of defendant, and if so, the date plaintiff reported it and to whom; and identify all documents and/or witnesses which support plaintiff's allegations of an unlawful employment practice.

25. Have any statements been taken from or made by any party or nonparty pertaining to this lawsuit? For purposes of this request, a statement previously made is: (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, video, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

    a. The name and address of each person making a statement;

    b. The date on which the statement was made;

    c. The name and address of the person or persons taking each statement; and

    d. The subject matter of each statement;

    e. Attach a copy of each statement to the answers to these interrogatories;

f. If you claim that any information, document or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

These answers to interrogatories require supplementation as new information is acquired by you. Objection will be made at the time of trial to the introduction of any evidence sought by these interrogatories which has not been disclosed.

Dated: April 19, 2022

MICHAEL O. FREEMAN
Hennepin County Attorney

Matthew S. Frantzen

Matthew S. Frantzen (#332793)
Katlyn J. Lynch (#398242)
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Katie.Lynch@Hennepin.us

ATTORNEYS FOR DEFENDANT HENNEPIN HEALTHCARE SYSTEM, INC.

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

TO:_____

_____

_____

The undersigned hereby authorizes the above-named entity/individual to release to the Hennepin County Attorney's Office and its authorized representatives all employment, contract, payroll and personnel records pertaining to the undersigned. I further authorize release of any other information concerning my eligibility for rehire and/or continued employment, and other conditions of my past or present employment, and to make excerpts, summaries, and/or photocopies of all or any portion of such records and information.

NAME:

SSN:

DOB:

Dated:_____ _____

Signature

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

TO:_____

_____

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SSN:

DOB:

Dated:_____ _____

Signature

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SSN:

DOB:

Dated:_____ _____

Signature

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

TO:_____

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NAME:

SSN:

DOB:

Dated:_____ _____

Signature

Print Form

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form may not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1| Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2| If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3| In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4| Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5| Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.
EXAMPLE: _*jh*_ All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6| Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name_____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____ State_____ Zip code _____

Daytime phone _____ E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____ Last name_____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9

Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

Or legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

Print Form

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

Print Form

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form may not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1| Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2| If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3| In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4| Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5| Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.
EXAMPLE: _*jh*_ All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6| Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

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1 Patient information

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Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____ State_____ Zip code _____

Daytime phone _____ E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____ Last name_____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
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☐ Other information or instructions _____

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☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

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Patient's name _____

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Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9

Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

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MM DD YYYY

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7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name_____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____ State_____ Zip code _____

Daytime phone _____ E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____ Last name_____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9

Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

Or legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

Print Form

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

Print Form

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form may not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1| Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2| If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3| In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4| Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5| Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.
EXAMPLE: _*jh*_ All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6| Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name_____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____ State_____ Zip code _____

Daytime phone _____ E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____ Last name_____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9

Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

Or legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

Print Form

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.